STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. Y-09/08-410
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department for Children and Families regarding the amount of petitioner's patient share under the Long-Term Care Medicaid program. The issue is whether the Department correctly determined the amount of petitioner's reasonable medical expenses when calculating her patient share. The decision is based upon the testimony of petitioner's son, the briefs, and materials submitted by the parties.

FINDINGS OF FACT

1. The petitioner is an eighty-five-year-old woman who has been diagnosed with spinal stenosis, hypertension, Ogilvies Syndrome, vertebral fractures, cognitive decline, and depression.

2. The petitioner's son, N.S., has power of attorney for petitioner and has handled petitioner's applications with the Department and with the Department of Disabilities, Aging, and Independent Living (DAIL).

3. At all times pertinent to this case, petitioner is eligible for Choices for Care benefits through DAIL. Petitioner was initially approved for Choices for Care while she lived in her home. The last Home Based Service Plan was approved on or about May 25, 2008; the plan paid for 51 hours every two weeks for personal care including assistance for (1) activities of daily living for dressing, bathing, personal hygiene, bed mobility, toilet use, transferring, mobility, eating, meal preparation, medication management; (2) additional incontinence assistance; and (3) the maximum time allowed for instrumental activities of daily living. In support of petitioner's eligibility, her treating physician completed a PATH 228 form documenting her ongoing needs for personal care services.

4. The Choices for Care program is a Medicaid Waiver program that provides long-term care. The Department calculates patient share or the amount an individual pays towards their care.

5. While petitioner was at home, the Department calculated petitioner's patient share. In a decision dated March 31, 2008, the Department determined that petitioner's patient share was zero. As part of their calculations, the Department allowed a deduction for $1,595.20 in uncovered

medical costs including uncompensated personal care services provided by N.S.

6. The petitioner was unable to remain at home and was admitted to an Enhanced Residential Care (ERC) home on or about July 5, 2008.

7. Petitioner's Choices for Care was amended to an Enhanced Residential Care Service Plan effective July 5, 2008.

8. On or about July 18, 2008, the Department issued a notice changing petitioner's patient share to $1,173.33 due to the changes in petitioner's Choices for Care program.

9. Petitioner returns to her home two weekends per month. According to N.S., his mother is depressed and her visits home are meant to alleviate her depression. When petitioner is home, N.S. is responsible for meeting petitioner's ongoing personal care needs.

10. N.S. and the ERC signed an addendum to petitioner's Admission Agreement for Enhanced Residential Care and an addendum to petitioner's Admission Agreement for Assistive Community Care Services Program on July 29, 2008. The addendums state:

> [ERC] agrees that you will be going home two (2) weekends every month. During these weekends, [ERC] will not bill Medicaid for Choices for Care Enhanced

> Residential Care services or Assistive Community Care Services. You will be responsible for the associated cost of providing care service in your own home during these weekend stays.

11. On July 31, 2008, N.S. wrote the Department explaining that petitioner is home two weekends per month. Petitioner requested that the Department recalculate petitioner's patient share by adjusting the medical expense deduction. N.S. stated that petitioner paid for 96 hours of supervision and services per month totaling $1,152 ($12.00 per hour at 96 hours).

12. On or about August 8, 2008, the Department issued a decision denying petitioner's request for an adjustment of her medical expense deduction. The Department wrote:

> It's your choice to go home two weekends a month. The Choice for Care program consider this a visit with the family member's, no PCA coverage would be pay or allowable deduction.
>
> ...No medical expense adjustment. Patient share for medical services will be as is.

13. On or about August 28, 2008, N.S. sent the Department additional documentation including letters from petitioner's treating physician and petitioner's social worker. N.S. wrote that petitioner's treating physician prescribed weekend visits on June 12, 2008 as treatment for depression prior to her admission to the ERC.

14. Dr. K.M. is petitioner's treating physician. His August 25, 2008 letter states:

> It is, in my opinion, beneficial for [petitioner] to return home on a regular basis. At [petitioner's] last office visit, 6/12/08, I discussed other living options. It is important for [petitioner] to have frequent home visits which are excellent therapy for depression.
>
> If you have any questions, please feel free to call.

15. E.S. is an eldercare clinician. In his written statement of August 15, 2008, E.S. supports the decision that petitioner return home "to prevent a relapse of her clinical depression".

16. The Department did not issue a new decision. N.S. filed an appeal on behalf of petitioner on or about September 11, 2008. A hearing was held on October 3, 2008.

ORDER

The Department's decision is reversed and remanded consistent with this decision.

REASONS

The Department's policies determining the amount of patient share for Long-Term Medicaid recipients are found at M430-432. M430 states, in part:

> Once the department determines individuals are eligible for long-term care including waiver and hospice services, it computes how much of their income must be

> paid to the long-term care provider each month for the cost of care (patient share). A patient share is computed for an individual in a medical institution or who qualifies for home-based waiver services as part of the special income group (M200.23(b)) or as medically needy (M200.3). The department determines the patient share amount at initial eligibility, eligibility redeterminations, and when changes in circumstances occur.
>
> An individual's patient share is determined by computing the maximum patient share and deducting allowable expenses. Sections M431-M431.2 describe how the department determines the maximum patient share. Sections M432-M432.32 describe allowable deductions from the patient share. The actual patient share equals the lesser of either the balance of a patient's income remaining after computing the patient share or the cost remaining after third party payment.

Reasonable medical expenses are an allowable deduction provided the criteria in M420-M422 are met. M432(d).

Personal care services are considered an allowable medical deduction. M421.2. In addition, M421.2 states:

> In determining whether a medical expense meets these criteria, the commissioner may require an individual Medicaid group to submit medical or other related information to verify that the service or item for which the expense is incurred was medically necessary and was a medical or remedial expense. The patient's physician shall verify medical necessity with a written statement or prescription specifying the need, quantity, and time period covered. (emphasis added).

The applicable provisions for personal care services are found at M421.23 which state, in part:

> The department will allow a deduction for noncovered personal care services provided in an individual's own home or in a level IV residential care home when they

are medically necessary in relation to an individual's medical condition.

(a) Deductible Personal Care Services

Deductible personal care services include those personal care services described in M740.3 and assistance with managing money. They also include general supervision of physical and mental well-being where a physician states such care is required due to a specific diagnosis, such as Alzheimer's disease or dementia or like debilitating diseases or injuries. Room and board is not a personal care service.

...

(c) Documentation

To document the need for personal care services, the physician must submit:

- a plan of care (PATH 228B);
- a list of personal care services required;
- a statement that the services are necessary in relation to a particular medical condition; and
- a statement that the level of care provided by a particular level IV residential care home is appropriate or, if the individual is not living in a level IV residential care home and the services are not provided by a home health agency, that the provider is qualified to provide the service.

Petitioner is a severely disabled individual who needs assistance with her personal care. As part of her initial eligibility for Choices for Care, her treating physician documented those needs by completing a PATH 228. Her need for personal care assistance did not change when she was admitted to an ERC. Her need for personal assistance is not

diminished when she is at home for regular visits. Based on petitioner's ongoing eligibility for Choices for Care, there can be no question that personal care services are medically necessary.

At hearing, the Department raised the question of whether there might be double dipping if a medical expense allowance for personal care services was allowed for the periods petitioner was at home while the ERC was paid. However, petitioner entered into an agreement with the ERC in which the ERC does not bill Medicaid for services when petitioner is at home two weekends per month. This agreement prevents any potential for double dipping.

The Department argues that the use of disjunctive language in M421.23 means that an individual can receive coverage for personal care services either at home or in a level IV residential care home. The language reflects what commonly may occur. However, there is no express language barring the coverage for personal care services in situations where an individual is receiving care both at home and in a Level IV facility given his/her individual needs. The Medicaid program is a remedial program whose provisions should be liberally construed in favor of individuals seeking necessary medical care. Christy v. Ibarra, 826 P.2d. 361

(Court of Appeals, CO 1991). To disallow an allowance for personal care services here is counterproductive to the purposes of the Medicaid program.

Petitioner was denied because the Department determined that her visits home were voluntary. She was not officially denied for lack of verification. However, petitioner, understanding that additional information was needed, submitted additional verification to rebut the notion that petitioner was just visiting. Although the Department may request verification under M421.2, the Department did not do so, and the Department did not issue any denials dealing with verification.[1]

Petitioner submitted a letter from her treating physician supporting regular home visits to deal with depression. N.S. corroborated this need through his testimony. There is sufficient medical documentation to support the medical necessity of regular home visits.

There is a missing piece in the documentation. There needs to be more documentation of what personal care services are required when petitioner is home.

[1] There was some discussion at hearing about verification for the home maintenance allowance but this is not an issue in this case.

The Department's decision to deny a medical care deduction for personal care services during the periods petitioner receives services in her home is reversed. The case is remanded to determine the appropriate amount of the medical services deduction. 3 V.S.A. § 3091(d), Human Services Board Rule 1001.4(D).

# # #